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ORIGINAL DEPARTMENT.

COMMUNICATIONS.

COMBINATION OF THE CUTANEOUS AND MUSCULO-CUTANEOUS PLANS OF AMPUTATION.

BY J. P. M'GEE, M. D.,

Of Trenton, Tenn.

In the *Half-Yearly Compendium of Medical Science*, for January, 1876, page 257, in an article taken from the *Medical Times*, of August 7th, 1875, Professor D. Hayes Agnew describes, gives the reasons for, and advantages of, the plan above indicated.

During the late war between the States, at the battle of Jonesboro, Georgia, in November, 1864 (now nearly twelve years ago), at the field infirmary of General Cheatham's division, of which I was in charge, we were forced to make several amputations. The reasons for the "combined" plan, so clearly given by Professor Agnew, had often presented themselves to my mind, though I had not known it performed.

A private soldier was brought in, requiring amputation of the right leg at the point of election, and I determined to make the experiment of what I deemed, not a new operation, but a modification of a very old one.

Accordingly, assisted by Surgeon J. L. Alston, now of Haywood county, Tennessee, and in the presence of Chief Surgeon Frank Rice, and, I think, Brigade Surgeon R. W. Mitchell, both of Memphis, Tennessee, I performed the operation, as follows:—

The anterior flap was made and raised as is usual in the double flap amputation at this point. Then an oval flap was made posteriorly, cutting through the skin and integuments, down to the muscular fascia. I did not "raise" or dissect up this flap at all, but, seizing the limb just above the flap, retracted it as far as possible, transfixed the leg, and cut the muscular portion of the flap from within outward, shaving close along the edge of the integumentary flap, leaving no pouting redundancy of gastrocnemius and soleus to be sliced off or "retrenched," as Professor Gross would express it, before dressing the stump. I found this mode quite as easy as the old, and easy and proper coaptation of the parts effected with unusual facility.

This man was sent by rail the same day to the permanent hospital in the rear, so that we knew nothing more of the case. This plan of operating, however, seemed to offer such evident advantages that I determined to adopt it in future, as did also Surgeon Ashton, I think.

Afterward, during the war, as well as since, I have had many opportunities to test it and observe its advantages, and can state that each trial of it since its first performance in November, 1864, has convinced me still more strongly that the "combined" plan possesses all the solid advantages claimed for it by Professor Agnew, besides being, in certain localities, much more easily and quickly executed.

From my experience and observation of it, however, I am clearly of opinion that it is much better adapted as a modification of the "double flap" than of the circular method, and must be pardoned for thinking that, as a rule, it is better to retract rather than to dissect up to an distance the integumentary flap.

Though strongly impressed with the material advantages of the modification, it had never occurred to me to publish it; and I am glad I did not, since it is now presented to the profession under the great name of one of the most learned, skillful, and eminent of American surgeons. I do confess, however, to a certain satisfaction and pride in being able to bring to the support (if it be any) of Professor Agnew's article an experience with this "combined flap," reaching over eleven years.

VERATRUM VIRIDE AS A REMEDIAL AGENT IN PNEUMONIA.

BY W. W. ALEXANDER, M. D.,
Of Athens, Tennessee.

This disease, which is unusually prevalent this season in many localities, is usually ushered in with a severe chill or rigor, and may or may not be preceded, for several days, by a feeling of lassitude, catarrhal symptoms, cough, etc., when, if absolute rest is enjoined and other prudent measures taken, serious pulmonary trouble may be avoided; but, as a general thing, the aid of a physician is not sought until the alarm occasioned by grave symptoms prompts the call.

The doctor, upon his arrival at the bedside, will usually find a rasping and hurried respiration, a quick, and often strong pulse, circumscribed redness of one or both cheeks, brown or bloody sputa, jactitation, anorexia, a sense of oppression about the chest, rather than pain, except during a full inspiration, or the effort to make one, a change of position, or while coughing, unless the *pleura* be involved, which is frequently the case, when the pain is not only more constant but sharp. But the purpose of the writer is not so much a disquisition upon a malady with which most of the readers of the REPORTER are presumed to be familiar, as to commend the controlling influence exerted upon the inflammatory stage by the judicious employment of *veratrum viride*. This potential drug has become our chief reliance in *pneumonitis*, and diseases of that type. We have used fluid extract and also Norwood's saturated tincture, most frequently the latter, which according to the formula of Dr. Norwood we mix with syr. scil., equal parts, agitating thoroughly in a pint vial, and labeling with the word CAUTION plainly written above the directions. For an adult we prescribe six to eight drops, commencing with the minimum dose, and generally increasing, if necessary, every two hours to four hours, according to the urgency of the symptoms, until the maximum dose has been reached (we never allow the patient to have more than eight drops unless administered by our own hand; while watching the effect we once gave ten drops in two consecutive doses, with good effect and no unpleasant action), which we continue until the pulse falls, the skin softens, and the heat subsides, or other manifest improvement, such as placidity of countenance, easy respiration, and subdued color, etc. We invariably direct the suspension of the medicine for a few hours, should it occasion vomiting, and upon its resumption a reduction of the dose. If nausea or perspiration occurs during its administration, we reduce the quantity or lengthen the intervals between doses, and discontinue it entirely when all inflammatory symptoms have disappeared, which we are often able to do in two or three days.

We usually precede the exhibition of the veratrum viride by a mercurial cathartic, unless contra-indicated. We often follow it with a syrup extemporaneously made by boiling a half ounce of senega roots in a pint of water for twenty minutes; we sometimes add to the senega a drachm of squill and as much or more of liquorice root or extract; while the decoction is hot, we dissolve two drachms of muriate of ammonia in it, and sweeten with honey or loaf sugar after it is strained or poured off from the dregs. Of the senega syrup we direct a tablespoonful at intervals of two hours while the expectoration is viscid and difficult. In some cases milk punch will be found useful; when there is much prostration we sometimes prescribe, with advantage, one spoonful of spirit frumenti to two of new milk, and direct one tablespoonful of the mixture, combined with loaf sugar, to be administered at intervals of two hours, if it should agree with the patient, which will be known by its effects; if useful, it will add to his comfort, but if it creates or increases restlessness, causes the head to ache, or is offensive to the stomach, it should be discontinued. Wine whey may sometimes be substituted. We generally restrict the diet to milk, corn gruel, rice water, flaxseed-tea or mucilage of slippery elm or gum arabic; after the fever is subdued we allow animal broth, though the milk diet may be safely continued until con-

valescence is established; then buttered toast, roasted Irish potatoes mashed up with a little salt and butter. After the bowels are thoroughly evacuated we do not often care to have an action oftener than once in forty-eight hours, unless specially called for by persistent fever and great restlessness, furred tongue, etc. We prefer as an aperient small doses of castor oil, adding a few drops of oil of turpentine to each dose of oil, to prevent the oil colicing. The juice from stewed fruit is often grateful to the patient, and may generally be allowed in moderate quantity. The substitution of buttermilk for sweet milk, in some cases, may be admissible. For the cough, which sometimes lingers, a syrup made of the bark of the sycamore tree, made by boiling an ounce of the fresh bark in a pint of water, and adding loaf sugar or honey sufficient to make a syrup, is good and very palatable. A little ipecac, morphia, etc., may sometimes be advantageously added to the syrup; without these additions it may be taken by the spoonful, *ad lib.*, when the cough is troublesome. During the progress of the malady, at any stage, we are in the habit of prescribing pulv. Doveri in five or eight-grain doses during the night-time, repeating after four hours, if necessary, to secure sleep, unless contra-indicated by constipation or head symptoms.

We sometimes add a grain or two of calomel to the Dover's powder, if called for by a bilious condition. Blisters are frequently of much benefit. They should be large enough to cover the affected lung or lungs, and rarely ever be resorted to until after the acute symptoms have been subdued. If a stitch or pain remains after convalescence is established, croton oil liniment will be of much service. When there is bronchial irritation, the hoarseness and cough will often be promptly relieved by a good crop of pimples over the upper part of the chest, which may usually be brought out by two or three applications of the liniment. Local depletion with cups and leeches is often beneficial in the congestive stage, and warm poultices or dry heat, conveniently applied by filling a sack or stocking leg with hot salt or meal, will greatly promote the comfort of the patient; so, at some stages, will hot tea.

We formerly relied chiefly upon the lancet in the treatment of pneumonia, if summoned early, and we think we have sometimes jugulated the disease in the congestive stage; but we believe the injudicious use of this potent and often doubtful remedy sometimes *jugulates* the patient. We should not like to promise never more to bleed a case of pneumonia, but we do earnestly and conscientiously recommend, as a substitute for the lancet, in all cases when there is any doubt about the propriety of general bleeding, the veratrum viride. We have treated more cases of pneumonia this season than usual. We have pushed the veratrum in every case. We have not thus far used the lancet in a single case this year, except in one of apoplexy; nor have we cause to regret our reliance upon the veratrum, not having lost a case of pneumonia this season. It has been our chief reliance in the treatment of acute inflammatory diseases; our sheet anchor in pneumonia.

SCARLATINA COMPLICATING RUBEOLA.

BY R. C. TALBOT, M. D.,

Of Pittsboro, Indiana.

We are taught that no two diseases of an exanthematous character (or I might say zymotic) will manifest themselves at the same time, on the same person. But the cases of which I shall endeavor to give a brief history do not concur with that theory. Hence, I have hesitated to report them, as I thought many would doubt the truth of my statements. Yet such are facts, but cannot be proven to the profession, as they were not seen by any other physician until later in their course, when they were seen by Drs. Eastman, of Brownsburg, and Brill, of this place.

Jan. 17th, 1875. I was called to the house of J. H. at 8 P. M.; was requested to examine and prescribe for Nettie H., a bright girl of about 11 years. Had been sick for about twenty-four hours, with the following symptoms:—Fever; nausea, with some vomiting; slight sore throat, with chilly sensations; tongue coated; bowels acting very well; no appetite, and some thirst. In the same room was Mollie H., another bright girl of 9 years, who, the parents told me, was just getting over measles. She had sore throat and swelling of glands of the neck, and as they thought she was better, I paid no heed to that, as we were having an epidemic of measles, in which the sore throat symptoms were quite prominent. Prescribed for Nettie in doubt, as they had both been exposed to the contagion of measles at the same time.

Jan. 18th, Nettie was worse, with diptheritic deposit on throat and a slight dusky hue on back; Mollie was worse, with the same kind of deposit on the throat, and quite an amount of glandular enlargement, with a general redness of skin, not differing much from skin as measles eruption begins to fade. I diagnosed scarlatina, but was still in some doubt, as I could hear of no other cases near, and there was plenty of rubeola.

Jan. 19th, Mollie was about the same, and Nettie was worse, with glandular enlargement of neck and throat; also the scarlatinal eruption well marked; I saw these cases each day, and there was slight improvement for a day or two, when both grew worse, Nettie having all the characteristic symptoms of first stage of rubeola, with the appearance of the eruption of this disease before the scarlatinal eruption entirely faded.

The desquamative stage was well marked in both cases; also both had suppuration of ears and glands of neck; and both had albuminuria; Mollie dying on the thirtieth day from time of first visit, and Nettie on the thirty-first; Mollie with uræmic convulsions and Nettie with hemorrhage from ears, nose and bowels; blood being thin, and not coagulable.

George H., aged 6 years, had rubeola well marked, and before the eruption faded the eruption of scarlatina appeared, filling the interspaces of the patches of measles eruption. He also had suppuration of glands of throat and ears, followed by albuminuria, but recovered after a long illness. I cannot exclude scarlatina from either of these cases, and rubeola was well marked in two; the first case I did not see early, but think she had rubeola, from the history and the length of time before desquamation, after scarlatina. These are, to me, interesting cases, and I would be glad to hear from the profession on the subject.

I will just say that the boy had the diptheritic deposit, and that the parents, all of same family, both were confined to bed with the same kind of sore throat, without the scarlatinal eruption, except in soft palate and throat.

—During the past month 227 patients have been treated at the Episcopal Hospital, and of this number 82 were discharged cured, 25 improved, and 2 unimproved. There were 3 deaths during the month, leaving 115 now under treatment. 2604 patients have been prescribed for at the dispensary for out-door patients.

Medical Societies.

COLLEGE OF PHYSICIANS OF PHILADELPHIA, MARCH 1st, 1876.

The meeting was opened at the usual hour by the reading of a paper on the

Excision of the Knee and Amputation of the Thigh for Disease of the Knee Joint,

by John Ashhurst, Jr., M. D., Surgeon to the Episcopal Hospital and to the Children's Hospital; Consulting Surgeon to St. Christopher's Hospital and to the Hospital of the Good Shepherd, Radnor.

After reciting the details of fifteen cases which he had treated, he passed to the general principles involved, as follows:—

The remarks which I have to offer may be put in the form of answers to the following questions, viz.:—

I. When should the surgeon abandon expectant measures in the treatment of knee-joint disease, and what may be considered the indications for a resort to operation?

II. Operative interference having been resolved upon, how shall the surgeon decide between excision and amputation?

III. When an attempt is made to save the limb by excision, how shall the operation be performed, and what shall be the after-treatment?

I. In order to give an intelligent answer to the first question, it is necessary to consider what are the prospects of recovery without amputation, and what the condition of the limb is likely to be if such a recovery can be obtained. To no class of diseases is the maxim "obsta principiis" more applicable than to joint affections, for if carefully treated from their beginning they seldom terminate badly. Of course, I am not speaking now of *wounds* of joints, for they are always very serious injuries, and too often end, even under the most favorable circumstances, in the loss of life or limb. But, in their early stages, inflammatory affections, of even the largest joints, whether following upon contusions or sprains, or of non-traumatic origin, are usually quite amenable to treatment. No doubt in some few cases there is such a constitutional predisposition to destructive bone-and-joint disease that, from a very slight cause, very serious consequences may ensue: thus, some years ago, a boy was under my care, who, from a fall on the ice, received a contusion of the elbow, followed, in a few days, by suppuration of that joint, and then by acute necrosis of the humerus and pyarthrosis of the shoulder, and whose life was barely saved by amputation at the shoulder joint; but such cases are happily exceptional, and, in a large majority of instances, if the patient can be at once put under careful and judicious treatment, a favorable result will follow.

But, unfortunately, these cases at first seem so trivial that they are too commonly neglected

until the disease is far advanced. A distinguished American surgeon, referring to his own case, spoke on one occasion of the time when he had the misfortune *not* to break his leg; had he sustained a fracture, he would have taken care of himself, and would have been well in a few weeks, but by neglecting a sprain he entailed upon himself a much longer period of disability. And so it happens that, in many (perhaps half) of the cases of joint disease which are brought to our hospitals, the time has already passed during which treatment, to be most efficient, should have been employed. Thus, of the ten cases of knee excision which I have reported to-night, in only one had the disease lasted less than one year, the duration in the other cases ranging from one to six years. I do not deny that, in some of these cases, recovery might perhaps have been eventually obtained without operation; but what kind of recovery would it have been? We do, indeed, meet men and women hobbling about on crutches, with knees bent, and limbs withered and deformed, and such results may, doubtless, in a certain sense, be called spontaneous cures; but what is here claimed is, that the limbs preserved by expectant treatment in these advanced cases of joint disease are inferior to the limbs secured by the conservative operation of excision, and little if any better than no limbs at all.

I have dwelt upon this point at some length, because I believe that there are still many members of our profession who look upon excision of the knee joint as a remedy of doubtful excellence, and who think that cases not bad enough for amputation should not be operated on at all.

In deciding whether an operation is required in any particular case of knee-joint disease, the surgeon must consider the age and general condition of the patient, the duration of the affection, and the stage to which it has advanced.

As regards *age*, no operation should, as a rule, be performed in cases occurring in very young children No doubt in some rare instances the life of the patient may be in danger from exhaustion produced by an inflamed and suppurating knee joint, and in such cases the surgeon must choose the least of two evils, and remove the source of irritation by amputating the limb. But in the large majority of cases it is better to temporize, to put the part in as good a position as possible by straightening the limb, dividing tendons if necessary, and, as it were, patching up the joint until the patient reaches an age when operative interference can be adopted with a better prospect of success. Excision of the knee is not a very successful operation in quite young children; these suffer more from confinement than those who are older, the restraint necessary during the after-treatment is more irksome to them, and they are, I think, more liable to the insidious development of tuberculous and other constitutional diseases. My own rule has been to postpone operation until the child has attained to at least the age of five years, and those cases which I have seen operated on by others at an earlier period of life have usually done badly. Again, in persons past the middle age, unless amputation is positively required to rescue the patient from impending death, it is better, as a rule, to avoid operation. The mortality after excision is so great in these cases that prudent surgery would, it seems to me, under such circumstances, dictate rather to take the chances of a cure by the efforts of nature, than to attempt to hasten recovery by operation.

The most favorable age for excision of the knee, as regards life, is from five to ten; but there is more risk then of consecutive shortening than at a later age, and the occurrence of bony union is perhaps obtained with more difficulty; hence the period of puberty is probably, upon the whole, that which may be considered to furnish the most favorable results.

In considering the *general condition* of the patient, when the question of operation arises, the surgeon must remember that these are essentially chronic cases, and that there can seldom be any justification for haste in operating, when by delaying a few weeks, or even months, the patient may be placed, by constitutional and hygienic treatment, in a more favorable condition to sustain whatever operation may be necessary. The presence of visceral disease, whether of the lungs or abdominal organs, must usually be considered a positive contradiction to excision, and under these circumstances, unless the local condition of the knee render amputation imperative, no operation should, as a rule, be performed. On the other hand, if the patient presents no evidence of visceral disease, and the general health seems to be directly suffering from the irritation arising from the diseased joint, the timely removal of the source of disturbance, either by excision or amputation, may prove the starting-point of rapid convalescence.

The *duration of the malady* must be considered by the surgeon in any case of knee-joint disease before deciding upon the propriety of an operation. I am not one of those who hold that a surgeon is bound invariably to wait a certain number of weeks or months to give, as is often said, a "fair trial" to other treatment before recommending an operation, for I believe that a thorough knowledge of the course and natural history of the disease will often enable him to say at once whether any particular case can or cannot be benefited by expectant measures. In their early stages, as I have before remarked, these knee-joint affections are quite amenable to treatment, and hence, putting out of the question some few cases of very rapid articular disorganization in which amputation is required (such as Case XIII), a judicious surgeon would, in cases of recent origin, endeavor to obtain, and would probably succeed in obtaining, a natural cure by placing the joint in good position, and at rest, by relieving intra-articular pressure by the use of continuous

extension, and by combating the morbid process by careful constitutional and local treatment.

And here let me digress for a moment to reiterate my profession of faith, so much objected to by my distinguished friend, Prof. Sayre, of New York, that these chronic joint affections, though unquestionably local diseases, are not of exclusively local origin, and that they require constitutional as well as local treatment. Would, I repeat, that another Abernethy might arise among us, and direct our attention once more to the Constitutional Origin and Treatment of Local Diseases!

In a recent case, then, an operation can seldom be required; on the other hand, if the disease has lasted many years, the process of natural cure (such as it is) being pretty well advanced, and the patient perhaps past the age at which excision would be likely to prove successful, the prudent surgeon would usually decline an operation, and content himself with straightening the limb either by gradual or immediate extension, then placing it at rest in a suitable splint, and simply aiding nature to complete the cure by anchylosis. But in the intermediate cases (and, as already remarked, these constitute a large proportion of those which come under the care of the hospital surgeon), when the disease has already lasted many months, or even several years, and when, from careful examination of the joint, the surgeon is satisfied that its functions are permanently abolished, an operation may often be properly recommended, as a means both of preventing suffering and of restoring the patient to active life more promptly than can be done by any other mode of treatment.

Even more worthy of consideration than the duration of the disease, is the *stage to which it has advanced;* and it is here to be remembered that the course of these joint affections varies much in different cases. No operation is, as a rule, justifiable as long as the disease is limited to the synovial membrane, no matter how long the patient may have been affected: no man in his senses would recommend either excision or amputation in a case of mere hydrarthrosis. Nor even in a case in which all the tissues of the joint are evidently implicated should an operation be hastily recommended, as long as the integrity of the parts is maintained, and a hope remains that by subduing the inflammation the usefulness of the articulation may be preserved. But when the relaxed condition of the joint, and the occurrence of consecutive dislocation, show that the crucial ligaments and semilunar cartilages have disappeared; when the limb is contracted and helpless, and the patient gives a history of repeated relapses from comparatively slight injuries; or, on the other hand, when the doughy semi-elastic character of the swelling shows the existence of gelatinous arthritis (the typical "white swelling" of the old writers), an operation may be properly resorted to, even though the limb be at the time in a quiet condition. When, in addition, the joint is in a state of suppuration, and, still more, if there be caries of the articular surfaces, an operation may be considered (other things being favorable) as almost imperative.

In saying this I am not ignoring the fact that Mr. Howard and other British surgeons have applied mineral acids to the interior of diseased knee joints, and have recommended this mode of treatment as a substitute for excision. But the results of the new method have not been uniformly favorable, and excision has been found so satisfactory in my own hands that I have not felt tempted to abandon a tried and proved operation for a procedure which at least has not yet been shown to be an improvement.

In may be observed, that in cases of *gelatinous* arthritis an operation may be properly recommended at a comparatively early period; the reason for this is that in the gelatinous form of the disease there is commonly no tendency to a spontaneous recovery; and though in private practice, among the more wealthy classes, such a case may be brought to a favorable termination, in the class of patients met with in hospitals a recovery without operation may practically be considered as out of the question.

II. The answer to my second question has, of necessity, been to a great degree anticipated in considering the first. The choice between excision and amputation must largely depend on the surgeon's belief as to the relative gravity of the two operations, and upon this point I have no hesitation in saying that I regard excision as a much more serious operation than the other. This is not a question to be decided by statistics (though I believe that, if the comparison be fairly made, the result would be found in favor of amputation), for excision is habitually performed in selected cases, while all the rest are reserved for amputation.

It is true that, among my own cases, I have had no fatal result to deplore after excision, though I have had one after amputation; but had all been amputated, the result would have probably been equally good: had all been excised, the mortality would, undoubtedly, have been much larger.

And this is, indeed, the true point of view from which to look upon this question. The surgeon's first thought should, undoubtedly, be of excision (for when successful the result is immeasurably superior to the best result of amputation), but before deciding upon this operation he should weigh well all the circumstances of the case, the age and constitutional condition of the patient, the extent to which the bones entering into the articulation are affected, and the facilities which will be afforded by the patient's surroundings for conducting the after-treatment (often prolonged and wearisome) to a successful issue. If, then, the patient be neither too young nor too old; if there be no evidence of visceral complication; if the disease be sufficiently limited to allow of its entire removal without taking away so much bone as would materially impair the usefulness of the limb, and if the patient be so situated that the question of the

time required for recovery is of secondary importance, the surgeon should choose excision, and by so doing will, probably, succeed in preserving for his patient a limb better than any artificial substitute, and, in most cases, better than could be obtained by the unaided powers of nature. Under opposite circumstances, provided that the case is bad enough to require any operation, amputation should be resorted to, and the surgeon who employs it under such, and only under such circumstances, will not have occasion to regret his decision.

III. A few words must suffice as to the mode of performing knee joint excision. Of the various incisions which have been suggested for exposing the articulation, three only have acquired general favor, viz.: the H incision, the *horseshoe* or U incision, and the simple *transverse* incision across the front of the joint.

The H incision was first employed by Moreau, has been adopted by Butcher, and is still preferred by some surgeons, including Prof. Hamilton, of New York. Provided that care be taken to make the lateral incisions far back, so as to allow of free drainage, this method anwers a good purpose, and is certainly easier for the beginner than either of the other forms of operation; it, however, makes an unnecessarily large wound, and is, in my judgment, far inferior to the operation by transverse incision.

The U, *horseshoe*, or *semilunar* incision was introduced by Mackenzie, and is now advocated by such high authorities as Prof. Humphry, of Cambridge, Prof. Erichsen, of London, and Prof. Gross, of this city. This method makes a smaller wound than the H incision, but does not afford such free access to the joint.

By far the best procedure, in my judgment, is that originally suggested by Park, in the postscript to his famous letter to Mr. Percival Pott, but which seems to have been first employed by Textor, Kemper of Exeter, and Sir William Fergusson. It consists in making a single transverse incision across the front of the joint, immediately below the patella, the extremities of the wound being carried well backward, so as to ensure free drainage during the after-treatment. When the limb is much contracted, as it often is in these cases, this incision, though made transverse to the axis of the tibia, forms, when the limb is extended, a somewhat obliquely curved wound, with its convexity downward, and thus really constitutes a flap operation. By dividing the ligamentum patellæ, the joint is opened, and the surgeon then proceeds to divide the lateral ligaments, and the crucial ligaments, if any portion of these is remaining.

The next step is to clear the condyles of the femur for the application of the saw, and it is here ordinarily recommended to dissect back all the overlying tissues, including the patella, which is subsequently to be removed from within; but this, in cases in which the parts are much thickened and infiltrated, is a very troublesome business, and when it is accomplished the result is not very satisfactory, for the cavity left by removing the patella almost invariably suppurates, and as a consequence abscesses form and leave persistent sinuses above the wound. Moreover, all that is really needed as a covering for the bone is the skin and subcutaneous fascia, and hence in my more recent cases I have simply dissected these back to the level at which it is meant to apply the saw, and have then cut directly down to the bone, thus removing together the extremity of the femur and the patella, with the diseased tissues by which the latter is surrounded.

For clearing the posterior surface of the condyles, I employ a very strong probe-pointed knife, with limited cutting edge, as recommended by Mr. Erichsen, having, I confess, a strong objection to the use of sharp-pointed instruments in the neighborhood of the popliteal vessels.

For making bone sections, I invariably employ a "Butcher's saw," reversing the blade so as to divide the bone from below upward. I may give a practical hint as to the use of this instrument, which is, that, in sawing in the manner indicated, the blade of the saw should be so fixed that its teeth will point *backward;* in sawing *downward*, the force of the arm is applied in *pushing*, but in sawing *upward*, in *pulling*, and the blade of the instrument should be arranged accordingly.

In removing the articular extremity of the femur, it must be remembered that the internal condyle is situated lower than the external, and that hence the line of section must be parallel to that of the free surfaces of the condyles, and therefore oblique to the axis of the femoral shaft, as otherwise the natural inclination of the limb would not be preserved. As, too, the epiphyseal line is higher in front than behind, a safe rule is that the condyles should be sawn in a plane *which, as regards the axis of the femur, is oblique from behind forward, from below upward, and from within outward.* The tibia should be sawn in a plane transverse to the long axis of the bone, with a slight antero-posterior obliquity to correspond with that of the section of the femoral condyles. In order to avoid interfering with the epiphyseal junction, and thus hindering the future growth of the limb, care must be taken not to remove the whole of the condyles; it is quite sufficient to take away the anterior portion—that which articulates with the tibia in the position of extension—a slice varying from half an inch to an inch in thickness, according to the size of the bone. From the tibia a still smaller portion may be removed, all that is needed here being to obtain a smooth section to be opposed to that of the femur. It is a good plan to snip off the sharp posterior edges of both bones with cutting pliers, so as to avoid all risk of injury to the tissues of the popliteal space.

The bone sections having been made, the surgeon should examine the condition of the sawn surfaces, and deal with any softened or carious patches by the free use of the gouge and osteo-

trite. The same plan may be pursued with any portion of diseased bone or cartilage beyond the line of section.

The next step of the operation is to clip away with scissors curved on the flat, or with Mr. Butcher's "knife-bladed forceps," any shreds of disorganized synovial membrane or ligament, taking care, however, not to disturb the floor of the wound, which should, if possible, be left intact.

The surgeon may next proceed to adjust the resected bones, when, if they cannot be brought into position by any justifiable amount of force, he should divide the hamstring tendons, and if this does not suffice must remove an additional slice of bone.

All bleeding vessels having been carefully secured by ligature, the wound may be brought together by stitches, and the limb adjusted upon the splint which is to be employed during the after-treatment. This adjustment is, I think, best effected while the limb is elevated to nearly a vertical position, there being, under these circumstances, no difficulty in keeping the bones together, while, if brought down to a horizontal line, there is a constant tendency to displacement, from the weight of the leg. The application of the splint should be completed before the patient is allowed to recover from the state of anæsthesia, which should be fully maintained during the whole operation.

Two points still require notice in regard to the operation itself: first, as to the control of bleeding during the operation, and, second, as to the mode of dealing with the patella.

I employ no tourniquet nor other means of interrupting the circulation during the operation; no large vessel is divided, and I believe it much safer to tie each small artery as it is cut than to run the risk (which is by no means only theoretical) of having consecutive hemorrhage from vessels which under temporary compression have retracted, and which do not bleed until the patient becomes warm in bed.

Even if the patella is not itself diseased, it should, I think, be removed; as the after-treatment aims at obtaining bony union, the patella is of no use, and statistics show that the risks of the operation are greatly increased by its retention.

The points specially to be considered with regard to the after-treatment are the choice of a splint, the position in which the limb is to be kept, and the frequency with which it should be dressed.

The most elegant, and altogether the best splint for the after-treatment of knee-joint excisions, is, I doubt not, that known as Price's, which consists of a posterior metal splint, cut away beneath the knee, with an arrangement by which it can be lengthened or shortened, a bracketed wooden external splint to guard against outward bowing (to which there is always a strong tendency in these cases), and a movable wooden foot-piece. The objections to Price's apparatus are its expense and its complicated nature. Butcher's "box splint" has answered a very good purpose in the hands of its introducer, but seems to me unnecessarily cumbersome; and the same may be said of the tin splint, which is, I believe, generally used in Boston. Dr. Watson, of Edinburgh, employs a posterior moulded splint, with an anterior bracketed rod, by which the limb can be suspended.

The splint which I have employed in all the cases upon which I have hitherto operated is based upon that originally introduced into the Episcopal Hospital by my colleague, Dr. Packard,* but with certain modifications which I think improvements. Dr. Packard's is a bracketed splint, the brackets being attached on either side to a posterior wooden splint which is interrupted below the knee, instead of to a side splint, as in Price's apparatus, or anteriorly, as in that of Dr. Watson. The deficiency in the posterior splint is filled by a trap, which, on the suggestion of our fellow-member, Dr. Edward Hartshorne, I have latterly had made, to be lifted in and out, and to be held in place by turn-buttons, instead of sliding, as in Dr. Packard's model. I have also added a movable foot-board, as in Price's splint, which I consider a very important improvement, and one which I observe that Dr. Packard has adopted in his latest published description of his apparatus. I have, moreover, dispensed with the laced-up leather side-pieces which Dr. Packard employs, finding that the limb can be much more securely as well as simply fixed upon the splint with broad strips of adhesive plaster and roller bandages than with these more complicated appliances. To guard against outward bowing of the limb, I have sometimes inserted a short wooden side-splint between the external bracket and the limb, but have latterly found it sufficient, with children at least, to pass a loop of adhesive plaster around the outer side of the limb, and fasten the ends of the strip to the internal bracket. I have not had occasion to employ the ingenious truss-pad arrangement suggested by Mr. Swain. The splint, before it is applied, should be thoroughly padded with cotton-wool, or, which is better, with picked tow, and the limb should be secured in position before the trap is put in.

The great merits of this splint are its simplicity and cheapness; it is, however, necessarily heavy, and, the wood getting saturated with the discharges, after a time it becomes offensive. I have, therefore, devised a wire splint, so arranged as to surround the lower half of the limb, bracketed at both knee and ankle, and provided with a foot-piece, which I purpose using for a patient upon whom I expect to operate in a few days, and which I hope will prove both lighter and cleaner than that which I have hitherto employed.

In what position shall the limb be placed after excision of the knee? Some surgeons recommend a slightly flexed position, believing that a somewhat bent limb is more useful than

* Trans. Coll. Phys. Philadelphia, 2d S., vol. iv, p. 342.

a straight one. This I regard as an error; a stiff *unresected* knee is no doubt better when anchylosed at a slight angle, so as to enable the patient to walk without swinging out his limb like that of a compass; but by excision the limb is necessarily so much shortened as to obviate any risk of this compass-like motion, and consequently the straighter it can be made the better it will be for the patient. I have had the opportunity of comparing the results of both methods in practice, and have no hesitation in deciding in favor of the straight position.

No rule is more important in the treatment of these cases than that the limb should be undisturbed after the operation. The wound, of course, must be dressed daily, but when the splint is once applied there should be no necessity for readjustment until the process of bony union is well advanced; six weeks is none too long for the splint to remain without renewal, and under no circumstances should it be disturbed within the first fortnight. I believe with Price and Swain that a neglect of this rule has been answerable for many of the failures of knee-joint excision. In the later stages of the after-treatment I have found it convenient to replace the bracketed splint by a single moulded pasteboard gutter, made to embrace the posterior half of the limb.

Should, unfortunately, caries or necrosis recur after excision, and render further interference necessary, a re-excision may be properly attempted, or, if this be thought impracticable, life may still be saved by amputation.

A very brief reference to the *statistics* of the operation must conclude this paper. The most elaborate statistics of knee-joint excision which have hitherto been published are those of Pénières, who has tabulated 431 cases of excision for *chronic disease*, the mortality of the whole number being over 30 per cent. The death-rate varies according to the age of the patient, being nearly 39 per cent. during the first five years of life, only 15.5 per cent. during the next quinquennium, then 19 per cent. up to the age of fifteen, 33 per cent. from that to twenty-five, and nearly 43 per cent. for all later periods. Of the whole number of cases, 247, or 57 per cent., recovered without further operation; six, or a little over one per cent., after re-excision; and 47, or nearly 11 per cent. after amputation. In 166 cases (38.5 per cent.), it was known that the patients had preserved useful limbs. These statistics, it must be remembered, include all the early cases, and many which at the present day would not be thought suitable for excision. By care in regard to the selection of cases, and by attention to the after-treatment, much better results can now be obtained.

The statistics of excision of the knee for *gunshot injury* have been particularly investigated by Cousin, Chenu, Lotzbeck and Küster. Cousin finds that 33 cases of total excision have given 28 deaths, or 85 per cent., while 11 cases of partial excision have given 10 deaths, or 91 per cent. Of the whole 44 cases, 38 proved fatal, a mortality of over 86 per cent. Chenu's figures, derived from the records of the Franco-Prussian war, show a still larger death-rate, 37 complete excisions having given 33 deaths, or 89 per cent., and 65 partial excisions 62 deaths, or 95 per cent., the whole 102 cases giving 95 deaths, or over 93 per cent. Lotzbeck's and Küster's statistics, though somewhat more favorable, are still sufficiently gloomy, 66 cases collected by the former writer giving 48 deaths, or nearly 73 per cent., and 101 cases collected by the latter giving 66 deaths, or over 65 per cent. When we compare these figures with the death-rate of amputation in the lower third of the thigh for gunshot injury (55 per cent according to Légouest, 50 per cent. according to McLeod), we cannot, I think, but indorse the dictum of Guthrie, that "wounds of the knee joint from musket balls, with fracture of the bones composing it, require immediate amputation," and conclude that the operation of knee-joint excision should be banished from the practice of military surgery.

For lesions of the knee joint from traumatic causes other than gunshot injury, excision might properly be attempted, if the patient were young and healthy, and the destruction of parts comparatively slight. The number of cases in which the operation has been performed under such circumstances is, however, too small to be of value for statistical use.

After the reading of the preceding paper, Dr. John H. Packard called attention to some points in reference to the splint devised by him.

Dr. H. Lenox Hodge said:—In my cases of excision of the knee I have always used a splint similar to the one exhibited to night by Dr. Ashhurst. In the treatment of excisions of the knee it is of the greatest importance that the limb should be kept perfectly still and firmly attached to the splint. These objects are well attained by means of strips of adhesive plaster applied like a bandage to the splint and limb. Any plan of lacing would be much less efficient, as it would allow more motion, and would be more apt to loosen and to constrict the tissues unevenly. That portion of the splint which is beneath the line of excision should be capable of being removed with the least possible jar to the limb. This object is well accomplished in the splint above alluded to, or by attaching a hinge to one side of the movable piece. A sliding portion with a tongue and groove would be very apt to become tight and difficult to move, by the swelling of the wood from absorption of the discharges.

In addition to witnessing the result in children, as shown by Dr. Ashhurst's patients to-night, it will, no doubt, be interesting to the College to see the result in adults, and I shall take an early opportunity to exhibit two cases, in both of which, after excision of the knee, the limb has proved exceedingly useful. One man does with ease the hard work of a driver of a street-car, and the other does active duty as a night nurse in the hospital.

EDITORIAL DEPARTMENT.

PERISCOPE.

Treatment of Chronic Bright's Disease.

The following is a summary, from the New York *Medical Journal*, of a plan of treatment recommended at the Bellevue Hospital, New York :—

Diet. This class of patients should abstain as much as possible from meat. The opinion has been expressed that the excessive animal diet accounts for the great prevalence of the disease in America. Milk should be substituted for meat, and should be associated with lime. Butter may be used; eggs, if they agree, and fresh fish in the morning. Fried fats should be carefully excluded, but cream may be taken without stint. Vegetables and fruits are *always* good, but those should be selected which contain the least amount of woody fibre. Rice and potatoes, therefore, may be used, but asparagus, turnips, cabbage, and notably beans, which contain woody fibre in large quantities, should be assiduously avoided. Onions may be eaten with impunity, and are rather beneficial.

For the Anæmia, iron should be administered from the first to last, and by preference, the tincture of the chloride. This preparation is assimilated with difficulty, hence should not be given alone, but combined with nux vomica, and to this spirits of nitre may be added, to assist the determination towards the kidneys. For example, ten drops of the tincture of the chloride of iron, ten drops of tinct. nucis vomicæ, and one drachm of sweet spirits of nitre, may be given three times a day. Cod-liver oil increases the red corpuscles of the blood, because it is digested by the liver, and the product enters into them as an ingredient. The irritability of the stomach may make it troublesome to take, but it should be relied upon as much as in the treatment of phthisis.

To Combat the Disease Itself, we have one agent which may be regarded as a specific against increase of connective tissue in the body, wherever the interstitial inflammation may occur, and that is the bichloride of mercury. It should be given in small doses, one-twentieth of a grain is the usual amount, and should be combined with a diuretic, to make it act upon the kidneys. For example, one-twentieth of a grain of the bichloride, one grain of digitalis, and one grain of quinine may be given three times a day, with the result of producing a specific action upon the kidneys, and will *raise* the specific gravity of the urine.

Attention to the Condition of the Skin will materially assist the embarrassed kidneys, and to do this we may have recourse to two things. If excessive œdema is present, the pressure produced shuts off the circulation to a great extent, and prevents removal of the fluid by diaphoresis. It is much better then to make punctures in the distended skin of the legs, and let the water drain away at once. No apprehension need be had with reference to this trifling operation, if the limb, when the punctures have been made, is wrapped with cloths wet in a solution of carbolic acid in water, to which has been added essence or oil of cinnamon. The latter is to correct the smell of the carbolic acid, and is also equally antiseptic. The second thing is, to rub the patient all over once a day with sweet oil. If extra diaphoresis is desirable, it can be best obtained by placing a blanket in an empty bucket and pouring hot water upon it, for in this way much less water is required, and then wringing it out and quickly applying it around the body and covering it with a dry blanket. The skin should be well oiled before the blanket is applied.

Scarlatinal Ear Disease.

This subject is one of such constant interest that we quote from the Edinburgh *Medical Journal* the following remarks upon it, by Dr. J. P. Cassells, M. R. C. S.:—

Scarlatinal ear disease, the most destructive of all the ear diseases, and the one most frequently met with in general practice, arises out of the naso-pharyngeal affection, which is so marked a complication of this exanthem The propagation of this congestion along the Eustachian canal, into the cavity of the tympanum, and thence to the mastoid cells, must have been frequently witnessed, even by practitioners not specially interested in the practice of this department of our art. When this, the initial step in the causation of the ear disease, has taken place, its progress and development proceed with extraordinary rapidity. The Eustachian canal, as a result of this tumefaction of its tissues, becomes concentrically closed; in consequence, there is a rapid increase in the congestion of the tympanic lining membrane, owing to the disturbanee which a closed Eustachian tube causes in the balance of the tympanic air-pressure. Inspection of the membrana tympani, at this stage, shows it to be, in general, unaffected by the congestion of the tympanic lining membrane. The temperature of the patient, at this period, is considerably increased toward evening, without a corresponding fall in it in the morning; there is much restlessness, rolling of the head, and more or less delirium, generally out of proportion to the violence of the general febrile attack. If now the interior of the ear is examined, the membrana tympani being still unaffected, except in a very slight degree, by the general congestion, it is generally possible to recognize through it the

deeply purple-colored tympanic lining membrane. As yet, there is no effusion into the cavity of the middle ear, although its flow is imminent. Up to this point in the progress of the malady it is possible, by the timely use of the knife, to bring about resolution of the diseased action; failing in this favorable and more desirable termination, the certainty nevertheless remains, that, by this means the disease is deprived of its power to commit damage. This stage in the treatment of the disease I call that of resolution and prevention.

The next step in the onward progress of the affection is more characteristic, is surrounded with more risk, and is of shorter duration than the preceding one; and because the resolution of the disease is no longer attainable, nor all the dangers to which it gives rise preventable, as they were in the earlier stage, I have named it the stage of preservation or cure. It is now that, owing to a marked increase in the hyperæmia of the tissues, and a diminution of the support usually afforded to the engorged vessels, there takes place an exosmosis of serous-looking fluid, which speedily fills the tympanum and mastoid cells. The pressure from this accumulation, constantly increasing as the fluid becomes greater in quantity, causes, at last, ulcerative absorption of one or several points in the parietes of the tympanic cavity, or mastoid cells; a process, I may remark, that goes on with astonishing rapidity, and, as may readily be supposed, leads to serious consequences. Indeed, the future of the case is determined, in a great measure, by this process, and the nature of the tissue in which it is set up; if it is the membrana tympani alone that suffers from the destructive process, less danger, both present and prospective, is likely to follow, than where the bony wall is broken down or perforated. The general symptoms from which the patient suffers, in this stage of the disease, are much graver than in the former one; there is, usually, agonizing pain complained of in the intervals of freedom from this symptom; there is often wild delirium, and not seldom a state of coma, due to the pressure of the effusion upon the labyrinth. Pain, as a symptom, however, is not, by any means, a constant one; when it is present, it usually indicates periosteal or meningeal hyperæmia. If the membrana tympani is now inspected, it will be found no longer possible to see the purple-colored lining membrane of the tympanum, by reason of the changes which have taken place in the membrana tympani itself It is now of a bottle-green color, with more or less bulging outward; or it may assume a yellowish color, if the contents of the tympanum have degenerated into pus.

It is in this stage of the disease that aural surgery, as a preservative, displays its advantages over the *laissez-faire* method of treatment. A free incision through the bulging membrane gives exit to the fluid, and arrests the destructive processes that may have been set up in some vital part of the organ. On the other hand, when the nature of the case is unrecognized, nature relieves herself by discharging the pus (happily for the patient if it be through the membrana tympani), with no other damage to the organ, even though a life-long otorrhœa is the consequence.

Inoculation of Diphtheria.

The *Lancet* says, on this subject, that the experiments of Trousseau and Peter were quite inconclusive. Trousseau dipped a lancet into some false membrane recently expectorated, and made punctures with it on his arm and on the velum palati. Peter made three experiments: in the first he allowed a small piece of false membrane, coughed up during tracheotomy, which lodged in his eye, to remain there, without attempting to wash it out; in the second he scraped his soft palate and tonsils with a pair of pincers in which was held a piece of false membrane recently coughed up; and in the third he inoculated a puncture of the mucous membrane of his lower lip with diphtheritic exudation.

Of these somewhat foolhardy experiments, only two can be considered as at all likely to have succeeded, and it is scarcely necessary to observe that scores of similar cases of escape from apparently certain infection with animal poisons might be cited, which yet only prove that there is a possibility of failure in the experiment. On the other hand, there is now abundant evidence that diphtheria can be inoculated, even in the lower animals. Thus Trendelenburg made experiments on pigeons and rabbits during an epidemic, and succeeded, in eleven out of sixty-eight experiments, in producing diphtheritic false membranes in the larynx by placing in it pieces of recent exudation. Oertel even states that he has succeeded in nearly every case in inoculating rabbits; but in many cases blood-poisoning, rather than true diphtheria, seems to have been produced.

Some experiments have recently been made on rabbits by Dr. Gabriel Duchamp. From his results he concludes that the false membranes, when placed in the larynx and trachea of the rabbit, may give rise to a true diphtheritic process, whilst, in the absence of false membranes, the other products from the human larynx in a case of diphtheria did not appear to give rise to it, although they were very poisonous. The injection of diphtheritic exudation suspended in water into the subcutaneous cellular tissue, or into the jugular vein, gave rise either to no results or to septicæmia or pyæmia; and inoculations of the skin with false membrane were equally without result, both in the rabbit and the horse. The number of experiments was, however, too limited to allow of our accepting these negative conclusions in an absolute manner. The subject is one of considerable importance, from its bearing on the mode of conveyance of the contagion of diphtheria; so far as experiments go at present, they would seem to show that the

primary contagion is local, and that its effect depends on the existence of certain conditions of the mucous or other surfaces favorable to its reception, which is entirely in accordance with clinical experience. The existence or non-existence of fungus in the false membranes, and its dependence upon their presence, is, it need hardly be said, an entirely different question.

The Spread of Cholera.

The following, from the *Practitioner*, is an abstract of Dr. Hirsch's conclusions from the whole of his inquiry upon this important subject:—

1. *Spread through the traffic of men.*—He says that the fact is confirmed on all sides that the introduction of cholera into Prussian Poland and Prussia was by the Galician raftsmen, and that this was invariably the case. Then from the towns or villages where cholera was thus introduced, and where it spread epidemically in some cases, it spread to places lying far from the river, by inland traffic. "The introduction," writes Hirsch, "was proved with certainty to be either through inhabitants of the place who had been attacked with cholera in other infected places, or through sick persons who had traveled to the place, and everywhere the course of the disease from an individual to his neighbors could be followed."

2. *Spread through dead bodies, linen, clothing, and straw.*—The carriage by dead bodies seemed probable, while that by clothing and straw was undeniable. With regard to soiled clothes he mentions the following case:—The clothes of a raftsman, dead of cholera, were stolen and taken to the house of a poor family in the village of Cruczno; the woman of the house and her child sickened with cholera; they were the first cases in the village, and from them proceeded a murderous outbreak. In a village near Culmsee there died all the inhabitants of a house into which linen from a cholera patient, dead at Culmsee, had been brought. After thorough purification of this house, no more cases occurred in that village. Two other similar cases are given.

With regard to straw, Hirsch speaks with some doubt, but refers to some apparent instances, and thinks it a matter to be carefully looked to.

3. *Spread through drinking-water.*—Hirsch seems to have no doubt of the influence in spreading cholera of impure drinking-water, but he still thinks it not decided which of the following views is correct, viz.: (1) whether the impure water contains something *specific;* or (2), whether the water merely exerts an injurious influence which *predisposes* to an attack. He relates several instances which certainly seem to give greater weight to the first explanation than to the second.

4. *Spread influenced by ground.*—It so happens that the ground-water during the whole of this year was low; in the Vistula the water-level was extraordinarily low. Hirsch does not, however, conclude much from this. He remarks that in many places the disposition of low-lying parts of towns to be attacked was very marked; there were, however, some exceptions, and he notices two: in Sodgorz, the high-lying places were more attacked than the low-lying, and one of the most severe outbreaks was in a group of houses on an elevation which dominates the whole place. In Elbing the worse outbreak was in a high and dry street, with houses built on pure sand.

5. *Influence of social distress.*—There is no doubt that cholera is very closely influenced by social distress and poverty. Hirsch does not trace out the connection, which, however, in many cases seem easy enough.

Salicylic Acid in Acute Rheumatism.

Dr. E. L. Warren writes to the Boston *Medical and Surgical Journal*:—

Recently we have received the announcement of Prof. Traube that in fourteen cases reported by Dr. Stricker salicylic acid has been used with such good results, and the effects of the remedy have been so uniform, that the profession has been strongly urged to try it. The following case, which has lately come under my observation and treatment, will perhaps serve to verify the usefulness of the new remedy.

Mr. W., a young man, twenty years old, a brakeman on the Boston and Albany Railroad, was taken February 13th with severe pain in the left ankle and top of the foot, attended with great heat and swelling. When called to see the case the following day, I found the patient lying on a lounge, and unable to move the foot without extreme pain. His pulse was 110, his skin dry, his tongue coated. The usual remedies were prescribed.

February 15th. The temperature was higher; the pulse was 120. There was no appetite, and the patient had taken to his bed. The inflammation had extended to both knees; the foot was somewhat better. The patient had no sleep the previous night. I prescribed sulphate of quinine and Dover's powder, alternating with syrup of lime. Hot applications were made to the joints, and lubrication with camphorated oil.

February 16th. The patient was no better; his pulse and temperature kept up, but he had slept better, from the effects of the Dover's powder. The inflammation had attacked the right wrist and the back of the hand, with the same amount of pain and swelling as in the foot.

February 17th. The patient was much the same. The pain and inflammation had extended to the muscles of the neck, and the man was unable to move his head from side to side without difficulty. I prescribed one drop of aqua ammoniæ in a teaspoonfull of water every three hours.

February 19th. The patient was somewhat better, and continued to improve after this date.

He went to work again in about a fortnight from the time he was first taken sick, the disease having run about its natural course.

Less than one week had elapsed before he was taken down again with the same trouble, commencing this time in the other foot, and extending to both knees as before. I was called immediately. The pulse was 120; the skin was hot and dry. The patient was very nervous and fretful; his tongue was coated; his urine was high-colored. Salicylic acid was given, seven grains in wafers every two or three hours, with no other treatment whatever. This treatment was commenced some time in the forenoon. After the first few doses marked improvement was noticed, and after the ninth dose, sixty-three grains in all, the patient was decidedly better. The skin was moist, the tongue nearly clean, the pulse 80. The inflammation had gone from the foot and knees; the patient's spirits were good; there was no appearance of inflammation in other parts of the body, as before, and he remarked that he felt well enough to get up and go to work.

A More Effectual Mode of Applying Iodine to the Interior of Certain Cysts.

Mr. Furneux Jordan, in some notes in the *Lancet*, remarks that he has found in practice two classes of scrotal hydroceles, in which the ordinary methods of treatment are either difficult to use or uncertain in their result. In boys and men there are occasionally encysted hydroceles of the testis, or the cord, which continue to increase in size, or in which treatment is urgently requested. In such cases, except in early infancy, acupuncture, or the use of a fine trocar, often fails to cure. The walls of the cysts are usually thin, and collapse so much when their contents are withdrawn that the injection of a fluid is uncertain. The end of the canula may be outside the cyst, and the iodine solution be consequently injected into the connective tissue at its exterior. In such cases the following is a reliable method of treatment:—"The cyst being well isolated, made tense, and brought near the surface, I pass through its centre a stout needle, armed with silk, and leave the threads hanging. The fluid quickly oozes away, especially if a little traction be made on the threads. I then, at one opening, wet the threads with iodine liniment (liniment because the quantity required is so limited) and draw the threads so as to leave moistened portions within the cyst. A little gentle friction will help to spread the iodine thoroughly over the lining membrane of the cavity. An hour later freshly moistened portions may again be drawn through, if the cyst be large, or if other methods of treatment have failed. On the other hand, in a very small cyst a single thread, moistened and kept in one hour, will suffice.

"Another class of cases are those of simple vaginal hydrocele, in which the injection of iodine and other ordinary methods of treatment are unsuccessful. An interesting case will best convey what I wish to say. A young man had a moderate-sized hydrocele. Trocar puncture and acupuncture repeated a few times failed, and consequently iodine tincture (undiluted) was injected. In a few weeks the collection had reached its old size. A silver-wire seton was then put in; while in, the cyst remained empty, but its removal was followed by reappearance of the fluid. I then, at three o'clock, passed through the cavity a double silk thread at two spots. In a few minutes, when all the fluid had oozed out, I drew the threads, moistened with iodine liniment, into the serous cavity. I directed him to repeat the process in an hour. He was so anxious to get well—he was shortly to be married—that he moistened the threads four times in six hours. At midnight the effects had become so sharp that he was glad to remove the threads as he had been directed. He remained at home one day only, and was shortly and permanently well.

"I venture to believe that no kind of hydrocele will resist this method of applying iodine, and consequently that the setting up of suppuration, even as a last resort, can rarely be necessary."

Avoidance of Phosphorus Poisoning.

At the Brussels Congress there was presented the following report of M. Crocq, "On the Sanitary Measures in Workshops where Phosphorus is Manipulated." The following conclusions were adopted: The section of public medicine expresses the wish, 1. That the use of red amorphous phosphorus be substituted for that of ordinary phosphorus in all match-factories. 2. Until the universal adoption of this radical measure, it recommends, in the actual conditions of manufacturing, the following measures, which are designed to prevent general toxic accidents, and more especially maxillary necrosis; installations of the manufacturing in sufficiently spacious rooms; powerful ventilation promoted by the aid of tubes, beginning at the ground and terminating in a drawing chimney; constant attention to cleanliness; together with these physical means, use as a chemical antidote, the spirits of turpentine. 3. Local accidents may be averted by astringent gargarisms, and above all, by the obligation imposed upon manufacturers to admit none into their workshops who, by oral examination, present dental lesions, such as penetrating decay, or any other affection of a nature to favor the deleterious action of phosphoric vapors. 4. Children not to be employed in workshops where phosphorus is used. 5. When the authorities allow the establishment of manufactories where that substance is used, they must impose these conditions and see that they are observed, for the interests of workmen as well as of manufacturers, who are criminally responsible for accidents resulting from their carelessness or neglect.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——"A Resumé of the Transactions of the International Medical Congress at Brussels" has been reprinted from the St. Louis *Medical and Surgical Journal*, in pamphlet form. The translation is by Dr. Geo. W. Wells. As the Secretary General of the Congress, Dr. Warlomont, has been suffering from pleurisy, the *Transactions* will not be out for two or three months. Hence this abstract is very timely.

BOOK NOTICES.

The Annual Report of the Board of Directors of the Pennsylvania Institute for the Deaf and Dumb, for the year 1875. Philadelphia. Printed by order of the Contributors. E. Deacon, Franklin Printing House, 38 Hudson Street, 1876.

In this journal we have endeavored to keep its readers posted on all matters of interest relating to the diseases of the ear, as well as to the instruction and condition of the Deaf and Dumb, not only of our own Commonwealth, but of the United States. By numerous communications in this journal* and in the *Transactions* of the Medical Society of the State of Pennsylvania,† the endeavor has been made to bring into favorable notice the improved method of teaching deaf mutes, so as to fit them for intercourse with the world and with their speaking brethren. We are happy to state that our efforts, with those of others, have not been in vain, for, in almost all of thirty-nine institutions in the United States, with its over four thousand pupils in attendance, the system which gives the pupil a knowledge of the concealed parts of the mouth, and of the movements of such parts, is making its way. This method will be of incalculable benefit for all who have once heard, for most of the semi-mutes, and a large majority of the total deaf, or congenital deaf mutes.

In the Pennsylvania Institution, the third in existence in the United States, founded in 1820, the new method has had much opposition to contend against, many of the intelligent directors believing that more good to the greatest number could be accomplished by the old method, and they referred with satisfaction to the seventeen hundred pupils sent out, and the great benefit of this training. Yet visible speech* does not prevent the employment of any means that are, or have been used by others. Imitation and mechanical aids are used whenever the pupil can be assisted by them; but when these fail, visible speech comes in to the assistance of the pupil.† There is a class of intelligent and bright mutes and semi-mutes to be found in this and all our institutions, who desire and languish for just such high mental instruction, and now they are about to receive it, for, according to the President's report, "It is the intention of the directors to have those pupils who have talent, to be instructed in linear drawing. They, also, in extension of the instruction now given in speaking, contemplate introducing visible speech as a branch of education, for semi-mutes, and such others as may be qualified to receive such instruction" (Report, p. 8). In the report of the Principal he gives this cheering salutation: "For the first time in several years, the doors of the Institution are open to all suitable applicants for admission to its privileges and advantages, owing to the additional building put up during the year."

Number of pupils on December 31st, 1874	224
New pupils admitted in 1875.....	109
Pupils re-admitted.....	5
Total population in 1875.	338

The number of congenital mutes admitted during the year, 33; cases of deafness from scarlet fever, 24; spotted fever, 15; typhoid fever, 3; catarrhal fever, 2; diseases of brain and ears, 13; from various other causes, as convulsions, whooping cough, measles, etc., 19 cases. "Of the one hundred and five families to which the above one hundred and nine pupils belong, eleven contain each more than one deaf mute child; seven of them contain each two deaf mutes; two contain each three; one contains four, and one five." L. T.

*Teaching the Deaf and Dumb to Speak by the Visible Method. Med. and Surg. Reporter, Nov. 23d, Dec. 7th, 14th, 21st, 1872. By Laurence Turnbull, M. D.

† On Deaf-Mutism, and the New Method of Educating the Deaf and Dumb. By Laurence Turnbull, M. D., Physician to the Department of Diseases of the Eye and Ear, Howard Hospital. Extract from *Transactions* Med. Society of Pennsylvania. Philadelphia, 1874, p. 7.

*See Medical and Surgical Reporter, November and December, 1872.

†See extract of letter to the writer, by Miss Fuller, Principal of the School for Instruction by Visible Speech, for the Deaf and Dumb. Boston, March 9, 1876. Extract from *Transactions* of Medical Society, State of Pennsylvania, p. 5.

THE

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A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M. D., EDITOR.

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THE RELATION OF LIGHT TO LIFE.

Recent studies in physics lead to the belief that light is a form of force capable of measurement and of application. It evokes energy by inherent attributes of its own, irrespective of heat; mechanically, it ranks as a new motive power.

That it has very intimate connections with the evolution of life, in both the animal and vegetable worlds, has long been known. Toward the close of the last century, ALEXANDER VON HUMBOLDT published a remarkable study of the subterranean flora in the mines of western Germany, and many subsequent observers have followed the suggestions he made.

The effect on the mental life of the action of light, and the importance of the organ of sight to give the higher relations of space, were emphasized by the learned naturalist, LORENZ OKEN. "Sight," he says, "is the light-sense. Without the eye, reason would not belong to man." Very recently, Dr. PONZA, the Director of the Lunatic Asylum at Alessandria, in Piedmont, has suggested and is carrying out the use of colored glass in the windows and in the ornamentation of the rooms, as a treatment of lunacy.

Dr. PONZA'S experiments consisted, in the abstract, in placing his patients in chambers colored red, blue, and violet, with most surprising results. In the red room he placed a melancholic man, who had refused his food, but who two or three hours afterward was found lively and hungry. In the blue chamber he placed a violent lunatic, who became much quieter within an hour. In a violet room he procured equally good results. Of all the rays of the spectrum, the violet are those which possess the most intense electro-chemical rays; the red are richest in calorific rays; whilst the blue, devoid of calorific, chemical, or electric rays, are in fact the negation of all excitement, and are most useful in calming violent accesses of fury. Couched in the choice neat phrases by which French authors commonly express themselves, the experiments seem conclusive. True it is, that we have reports of only a very few cases; that no indication is given of various sources of fallacy; that the accounts of the permanence of the cure are unsatisfactory: still, the fact remains, that a record has been made of a new method of treatment, the facilities of working and economy of which commend it to those working in the same line.

It is remarked by the editor of an English cotemporary: "That the gloominess of many old large asylums has a depressing effect upon the inmates, is seen by the surprising recovery of the latter when removed to better conditions; whilst, on the other hand, very light rooms and corridors are unsuitable to the treatment of many forms of acute disease. Many insane refuse to wear clothing unless dyed of a certain color. Why not seize the fact, and, treating it as a delusion or a hallucination, treat them

according to the color of their minds? It is a fact that some persons can detect the color of a material by feeling it. Suppose such an one in an insane state irritated by contact with material of a color from which, as the result of a delusion, he has a special aversion: how his case must be retarded unless the very conditions of his mind are recognized, and he is bathed in light of a proper tint."

Some of the most important recent researches on this subject were published in the *Transactions of the Royal Society of Edinburgh*, by Dr. DEWAR and Dr. MCKENDRICK. These careful observers consider that they have experimentally proved—1. That the impact of light on the eyes of members of the following groups of animals, viz., mammalia, aves, reptilia, amphibia, pisces, and crustacea, produces a variation amounting to from three to ten per cent. of the normal electro-motive force existing between the corneal surface and the transverse section of the optic nerve. 2. That this electrical excitation may be traced into the brain. 3. That those rays that we regard as most luminous produce the largest variation. 4. That the alteration of the electrical effect, with varying luminous intensity, seems to follow very closely ratios given by the psycho-physical law of Fechner. 5. That the electrical alteration is due to the action of light on the retinal structure itself, and is independent of the anterior portion of the eye; therefore, the natural supposition that the contraction of the iris might produce a similar result cannot be sustained. 6. That it is possible by experiment to discover the physical expression of what is usually called, in physiological language, fatigue. And, 7, that the method employed in this research may be applied to the investigation of the special organs of the other senses.

It will be seen that such results have a high psychological as well as physiological value. Now that we have attained to much more accurate photometrical methods than ever before, we may expect positive knowledge on these points, where previously much was necessarily left to guesswork.

In reference to the action of light on tissue change, it has been observed that the quantity of carbonic acid expired in a given time may be generally taken as a tolerably accurate indication of the rate at which tissue change is going on in the body. Moleschott found that frogs exposed to light expired one-twelfth to one-fourth more carbonic acid than frogs kept in the dark, and the brighter the light was, the more carbonic acid they did excrete. The increased rapidity in tissue change of which this was the indication might of course be due to the action of the sunlight upon the skin, but some recent researches of VON PLATEN seem to show that it is rather due to the action of light upon the eyes. He kept some rabbits as nearly as possible under the same conditions, but sometimes covered their eyes with black glasses, so as to exclude the light, and sometimes with white glasses, so as to allow it to act upon them. The experiments which he made in this way showed that when the light was allowed to reach the eye, the carbonic acid excreted was increased by one-sixth to one-seventh of its average amount.

Now, a moderate increase in tissue change in a fairly healthy organism leads to increased appetite, increased consumption of food, and a healthier condition of the organism generally, so that anything producing it must rank as a tonic. These researches, therefore, are of extreme interest, as they show what a very high place among tonics must be assigned to light, and the necessity of securing a good supply of it for convalescents and debilitated persons generally. They also tend to explain the weakly condition of the children in the crowded parts of large cities, as well as to some extent the languor which persons not unfrequently feel when they exchange country for city life.

We have not space here to describe the identity of the direction taken by the light force with that of the *phyllotaxis* and plant-climbers generally; this too is a most suggestive fact.

Notes and Comments.

The Use of Well Water in Cities.

According to the *Scientific American*, the State Geologist of New Jersey, in his recent report, calls attention to the habit, still in use in some of the older cities of New Jersey, of people drawing their supplies of water from old wells. In an analysis of the water coming from some nine wells in Princeton, five of them were found to contain free ammonia, albuminous matter, and chlorides, in excess. In tracing the effects of these waters, it was found, in almost all cases, that diarrhœa and typhoidal fevers accompanied their use. It is almost impossible to be sure of the good qualfty of any well which is surrounded by houses where drains and sinks empty into the surrounding soil. It would be well if the proprietors of large country hotels and summer resorts would not only look to their sources of water, but eschew well water entirely. For the health of their guests it is better, in all cases where running water does not exist, to seek their source of water from cisterns which are fed from the rainfall on the roofs.

Chloral in Pityriasis.

Dr. Martineau states in a French cotemporary, as the result of a large experience, that chloral is a very efficacious, if not certain means of treatment in this rebellious affection. The solution he used was of the strength of about forty grains to each ounce of water, and this he applied to the scalp each morning, by means of a sponge, using slight friction, and allowing it to dry. If the disease is recent, and the lotion is uninterruptedly used for a month, he predicts a certain cure. In the chronic and more obstinate cases, he recommends the continuance of the application of the solution until the disease disappears, as its daily use produces no inconvenience, whilst it relieves the itching.

Prolonged Baths.

In a visit to Leuk, some years ago, we witnessed the method there employed of giving patients baths of several hours' duration. In modern balneology, these prolonged baths, in which the patient remains six hours, or even a whole day, seem to be dying out of notice. Dr. Kisch thinks this a subject for regret. Prolonged baths of 37° or 38° C. are an admirable means for soothing irritated nerves, and influencing the skin by imbibition and saturation. The excretory organs are also stimulated by them, and the process of healing of open wounds and ulcers greatly assisted. They supply an admirable anæsthetic in cases of neuralgia and hyperæsthesia, or exposure of the cutis, and further, add a means of promoting the general metamorphosis of tissue and the expulsion of unhealthy materials present in the body.

Pills for Obstinate Neuralgia.

The *Bordeaux Médical* gives the following formula for obstinate neuralgia, especially ileo-lumbar neuralgia:—

℞. Valerianate of ammonia,
Quinine, ää gr.xxx.

Make into twenty pills and take from two to ten of them each day, increasing one pill per diem. After taking these pills for ten days, suspend their use for five days.

Alcohol in Medicine.

The First Section of the Brussels Congress made a report on this subject, that the only circumstance which establishes the necessity of administering alcohol, and when that agent cannot be replaced by any other, is the certainty of anterior alcoholic habits. In these cases alcohol becomes indispensable.

Correspondence.

Early Discharge of the Liquor Amnii.

Ed. Med. and Surg. Reporter:—

On the 29th of February I was sent for to see a negro woman, who gave me the following account of herself:—She was about twenty years old, the mother of one child, and was then pregnant with her second, and she did not think she was more than seven months "gone." She said that on the 27th of February—that is, two days before I saw her—while she was sitting still, suddenly, and without the least pain, about a pint of water came from her, and that it had been running from her more or less all the time since. Before making any examination, as she told me water was dribbling from her all the time, I thought I had a case of retention of urine; but on examining I became satisfied it was not from the bladder that this water came, as there was no distention of that organ, and the woman told me she could pass her water; still, she thought it was urine that was passing from her. I next made a vaginal examination, and satisfied myself that labor had

not begun. The woman told me she had not had anything like labor pains or pain of any kind; that she had not hurt herself in any way, nor had she passed any blood; said she felt pretty well, with the exception of being wet all the time; and she was very uneasy about herself, as she said she had nothing like this while pregnant with her other child, nor could any of the old women tell her of ever having seen anything like it before. I gave her a dose of opium, and directed her to keep quiet in bed, and to let me know if anything like labor pains came on. About two o'clock that night I was sent for, the messenger informing me my patient was suffering very much. On reaching her, about an hour afterward; I found her in labor, head presenting; the child was born in about an hour after I got there, and though very small, is still living. The woman informed me that the water stopped passing from her several hours before labor pains came on. There was no discharge of liquor amnii (or if any, so little that I did not notice it) after I got to her, and she insists that there was none during labor, nor for several hours before it began.

To me this is rather a novel case. In "Signs and Diseases of Pregnancy," by Tanner, on page 442, may be found a case reported very much like this one of mine. R. K. JONES, M. D.

Holmes County, Miss.

Quinine a Parturifacient.

ED. MED. AND SURG. REPORTER:—

It will not do to infer a general principle from a single fact, or a few isolated facts. The fact that one man dies, or that ten thousand men die, would not warrant the presumption that the whole race is thus doomed; but when it is observed that death is a fact of human experience, from Adam to the present time, then we may infer that mortality is an unalterable law, and that "death has passed upon all men."

The philosophy of Bacon substituted facts for hypotheses, and induction for speculation. He would look upon the effects, and by careful reasoning ascertain the causes, and thus reason from effect to cause, rather than from cause to effect. When laws are discovered from facts themselves, they become landmarks of truth.

Physicians are not infallible, and even in the field of their observations they are liable to be deceived and err in judgment; but when facts present themselves, and facts they are proven to be, so much the more should they guide and govern the physician in his practice.

As others are writing about quinine as a parturifacient, I conclude to add my testimony, and by a multiplicity of facts deduce a general principle.

Living in a malarial region, I have had occasion to give quinine under almost all circumstances, and have given it many hundreds of times to pregnant women, without the least unpleasant effect, and cannot recall a single instance in which it has caused abortion or premature labor.

I am satisfied that quinine has little or no effect upon the uterus in its quiescent state; but when labor has fairly set in, it has often, in my hands, proved more potent than ergot in stimulating uterine contractions. For several years I have been more careful to have quinine in my pocket than I ever was to be sure of my supply of ergot when called to an obstetric case.

The first case in which I used quinine as a parturifacient was that of Mrs. D., in April, 1868, in her second labor. The labor progressed satisfactorily until the head rested on the perineum, when the pain suddenly ceased, and there was complete inertia of the uterus. I gave six grains of quinine; in thirty minutes pains returned, gradually grew stronger, and in one hour and a half terminated the labor. Another case, four or five years ago, was extremely tedious on account of rigidity of the os. Morphine, ipecac., tartar emetic and chloroform were used, and after long suffering the labor terminated. The same patient, in a subsequent labor, was threatened with the same delay from the same cause. In addition to the rigid os, the pains were feeble and insufficient. I gave quinine, grs. vi, ipecac., gr. j; in half an hour the pains were more forcible, the os dilating, and a speedy termination of the labor.

Two years ago I was called, in consultation, in a case where the head had been resting on the perineum for several hours, with very feeble and insufficent pains. After starting a man for my forceps, I suggested to the doctor in charge to give grs. vj or viij of quinine, which was done. The pains soon improved, and the child was born without instrumental aid.

I have made it a rule to give quinine just before the completion of labor, even if it has not been previously indicated, thereby anticipating and preventing hemorrhage. I have never seen hemorrhage after delivery where quinine had been given, and have invariably observed that the woman suffers less from after-pains, and, altogether, has a better getting-up.

L. WOODRUFF, M. D.

Alton, Franklin Co., Ohio, March 23, 1876.

An Easy and Painless Mode of Extracting Foreign Bodies from the Nasal Cavity.

ED. MED. AND SURG. REPORTER:—

Rosa Westheimer, aged 2 years, was brought to my office in July, 1872, for the purpose of extracting a plum seed from her nose, which she had inserted a few hours previous. The seed filled the cavity completely, and was very slippery, consequently I could not get hold of it, and with each attempt to do so it moved further in. It was evident that the object could only be accomplished by getting an instrument back of it; this led me to think of the nasal douche, which would propel the seed forward. I placed the child in position for the nasal douche, with the head bent forward, and applied it to the free

nostril, and immediately after turning on the stream of milk-warm salt water the seed was forced out, and fell into the basin, with a loud sound, calling forth an exclamation of joy and relief from the anxious mother.

I have since then had occasion to extract other foreign bodies from the nasal cavity, and have used the douche as above, with like success. As I have no recollection of ever having seen it mentioned in medical works, and as it is so much easier than the usual method, causing no pain whatever, I tender it for publication.

Houston, Texas. M. PERL, M. D.

NEWS AND MISCELLANY.

Sanitary Amenities.

It is always a good sign when the public is awake to the importance of sanitary provisions to the material interests of their city. But even this praiseworthy sentiment may find too vigorous expression. An instance of it appears in the reply of the Washington *National Republican* to the New York *Sun*. The latter veracious newspaper commenced an article thus:—

"WASHINGTON DOOMED.—*A Frightful Epidemic the Probable Result of Boss Shepherd's Rascality.—Washington, March* 29.—Those terrible scourges, typhoid and typho-malarial fever, 'throat-rot' and diphtheria, are now prevailing to an alarming extent in this city, and are daily increasing in intensity and fatality."

To which the *Republican* replies with a table of mortuary statistics and the Report of the Board of Health, headed as follows:—

"SLANDERS REFUTED!—Detective Press Caught in the Act; Comparative Statement of Mortality; Lies of the Ishmaelite Exposed; The Doom Fixed Upon His Own City; Light Death Rate of the Capital; Curses Returned Home to Roost!"

Will not our respected cotemporary remember Talleyrand's motto?—*Surtout, pas de zéle.*

Erie County (Pa.) Medical Society.

The Erie County Medical Society met April 4th, and was called to order by the President, Dr. W. C. Evans.

The following gentlemen were elected delegates to the convention of the American Medical Society, to convene at Philadelphia on June 6th next:—

Drs. J. L. Stewart, A. S. Lovett, and C. B. Kibler.

The following gentlemen were elected delegates to the State Medical Society of Pennsylvania:—

Drs. W. C. Evans, William Faulkner and I. N. Taylor.

Dr. William Faulkner, of Erie, according to announcement made at the last meeting, opened the discussion on puerperal convulsions, which was highly instructive, and was listened to with marked attention by the members. He spoke of the seriousness of the trouble and the importance of exchanging views on the best mode of treating and conducting these cases. He urged the importance of bleeding, unless contra-indicated by the condition of the patient, in which position he was sustained by other members of the Society who participated in the discussion.

Adjourned to meet in Erie on the first Tuesday in July. A. S. LOVETT, M. D., *Secretary.*

Homœopathy at Ann Arbor.

A number of the alumni of the Medical Department of the University of Michigan, Ann Arbor, have circulated a protest against the half-recognition of homœopathy, forced on the Faculty of that institution by the State. The letter says:—

"We shudder at the fact that a Faculty in part composed of those whose names appear upon our diplomas, now join hands with those who teach this unblushing charlatanism, by freely giving their students the benefit of additional instruction, thus becoming an organized corps of colaborers in preparing them to practice a pretended system, that not only shames science, but is a by-word to simple common sense. When the advocates of "similia similibus curantur," and the law that the less the dose of a given drug the more powerful it proves to be, flaunt in our face their diplomas, bearing the same name and seal as our own, we can but estimate the value of ours, obtained when her name was without stain, as very sadly depreciated."

Dr. J. T. Woods, of Toledo, Ohio, leads the names.

Items.

—A detail of German army physicians will arrive here shortly. They are to inspect the Medical Departments of the United States.

—The Centennial Commission has received a letter from a citizen of Shelby, North Carolina, who desires to exhibit *fifty of the ugliest men in the United States* at the Centennial Exposition, and he wishes to know "if it will pay." He says: "I propose to get them out of the mountains of Western North Carolina." This item has a physiological interest.

—It is reported that the plague is on the increase in Bagdad. Nine or ten deaths from plague occur daily in that city.

—A registrar in the north of Ireland states, in his return for the December quarter of last year, that he registered a death occasioned by drinking ether, which he says has been extensively made use of in that locality for many years. The person in this case had been drinking ether for several days, not having taken any food.

—A census of Philadelphia, taken April 1, 1876, counted 817,000 inhabitants.

Personal.

—A cable dispatch this week brought intelligence of the death of the eminent Dr. Traube, of Berlin.

—Dr. Letheby, the distinguished English sanitarian, died recently.

—The Atlanta *Medical and Surgical Journal* for April says :—

"As we go to press, it is with feelings of no ordinary sorrow that we are called upon to announce to our readers the death of Dr. C. B. Nottingham, of Macon. The profession of Georgia will long and deeply mourn the loss of one so useful to the community; one so ornamental to the profession of his lifetime choice; one so respected and beloved by his brethren."

—The *British Medical Journal* announces the death of Sir John Cordy Burrows, President-elect of the British Medical Association. Sir John Cordy Burrows presented, at the meeting of the Association in Edinburgh last year, an invitation, "cordially inviting the British Medical Association to hold its annual meeting in 1876 at Brighton," and nominating him for acceptance by the Association as President for the meeting in 1876 and for the year ensuing.

Medical Society of the State of Pennsylvania.

The Twenty-second Annual Session will be held in the city of Philadelphia on Wednesday, May 31st, 1876, at 3 P. M. The appointments are :—To prepare—The Address in Surgery, Dr. D. Hayes Agnew, Philadelphia. The Address in Obstetrics, Dr. R. Davis, Wilkesbarre. The Address in Medicine, Dr. James Aitken Meigs, Philadelphia. The Address in Hygiene, Dr. Benjamin Lee, Philadelphia. The Address in Mental Disorders, Dr. John Curwen, Harrisburg. The Secretaries of County Medical Societies are earnestly requested to forward *at once* their lists of *Officers and Members*, with the *Post office address of each member*.

WM. B. ATKINSON, M. D.,
Permanent Secretary,
1400 *Pine Street, Philadelphia.*

QUERIES AND REPLIES.

Alcoholic Stimulants.

"Are alcoholic stimulants much used by the profession in general and hospital practice in your city?" J. G., Jr.

Alabama.

Reply.—The use of stimulants as medicine still obtains to a considerable extent in this city, but we believe we are correct in saying they are much less used than, say, ten years ago.—ED.

Pruritus of Pregnancy.

Dr. G. L. C., of South Carolina.—For the purpose of allaying the pruritus vulvæ and vaginæ originating during pregnancy, and from other causes, try unguent. spermaceti, one ounce; calomel, from one-half to one drachm; and extract of belladonnæ, one drachm; well mixed together. With this have the itching parts freely anointed several times a day, after previous ablution with tepid carbolized water. Fowler's solution, in minute doses, may be given at the same time. The ointment alone, however, has answered admirably in my hands, and I have found it superior to any of the reputed remedies for this troublesome affection. A. G. W.

Pulvis Glycyrrhizæ Comp.—Syr. Guaiaci.

In answer to inquiries, we have obtained, through the kindness of Professor Maisch, of this city, the following formulæ :—

Pulvis glycyrrhizæ (liquiritiæ) compositus seu pulvis pectoralis kurellæ.

R.	Pulv. fol. sennæ, Pulv. rad glycyrrh., Pulv. fruct. fœniculi, Sulphuris depurati, Sacchari optimis pulv.,	each two parts each one part six parts M.

—*Pharm. Germanica.*

There are two formulæ for syrupus guaiaci, as follows :—

R.	Guaiaci resinæ, Liq. potassæ, Sacchari, Aquæ,	one ounce half fluid ounce fourteen ounces q. s.

Macerate the guaicum in the sol. pot., mixed with two fluid ounces of water for two or three days; then percolate with water until eight fluid ounces are obtained, in which dissolve the sugar.—*James T. Shinn, Proc. American Pharmaceutical Association*, 1870.

Prepare a tincture by percolating one part guaiacum with four parts of fifty-six per cent. alcohol. Mix half a pound of this tincture with one pound syrup acaciæ and evaporate the alcohol. *Mouchon, Bull. gén. de Therap.*, 1855.

The first formula yields a transparent syrup, which mixes clear with water.

A correspondent wishes to know the source of the quotation, "Thousands die of medicable wounds."

We do not find it in Bartlett and similar works of reference.

DEATHS.

CALDWELL.—Died, at San José, California, February 16th, 1876, in the 57th year of his age, Dr. Augustin Byrne Caldwell. The deceased was a native of Princetown, Kentucky, and graduated at the Transylvania College of Medicine, in the year 1841.

HINKLE.—On the 16th instant, Maria, daughter of the late Dr. Philip Hinkle, in the 72d year of her age.

RIPLEY.—On Tuesday, March 28, 1876, of diphtheria, Eveleen, only daughter of Dr. John H. and Isabella M. Ripley, aged 6 years.

RUSH.—On the 4th instant, Stephen Yarger Rush, M. D., son of John and Catharine M. Rush, aged 2[illegible] years.

THOMPSON.—At Phelps, Ontario County, New York, on Monday, April 3, Caroline M., wife of Dr. Albert Thompson, and sister of the late Robert Denniston, in the 67th year of her age.

WESTERVELT.—At Plainfield, New Jersey, on Thursday, April 6, of consumption, Mary, wife of Dr. Richard H. Westervelt, of New York, in the 43d year of her age.